FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023770

Facility Name: 4621 CORPORATION D/B/A ST. MARTHA MANOR

Address: 4621 RACINE AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 784-2300 **Fax #** (773) 769-4621

IDPA ID Number: 36-2944224

Date of Initial License for Current Owners: 12/1/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) JEFFREY K. SINGER, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,862	1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,450	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,312	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,668	366		4,034	8
9	SNF/PED					9
10	ICF	41,133	446		41,579	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,801	812		45,613	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.41%

D. How many bed-hold days during this year were paid by Public Aid?
627 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/78

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/78 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	98,754	25,612	36,643	161,009		161,009		161,009			1
2	Food Purchase		376,546		376,546	(34,631)	341,915	(498)	341,417			2
3	Housekeeping	86,266	72,452	97,319	256,037		256,037		256,037			3
4	Laundry	393	19,217		19,610		19,610		19,610			4
5	Heat and Other Utilities			76,882	76,882		76,882	2,098	78,980			5
6	Maintenance	89,266	54,876	166,976	311,118		311,118	(10,096)	301,022			6
7	Other (specify):*											7
8	**TOTAL General Services**	274,679	548,703	377,820	1,201,202	(34,631)	1,166,571	(8,496)	1,158,075			8
	B. Health Care and Programs											
9	Medical Director			3,628	3,628		3,628		3,628			9
10	Nursing and Medical Records	803,326	119,218	234,351	1,156,895		1,156,895	(608)	1,156,287			10
10a	Therapy			10,932	10,932		10,932	(1,313)	9,619			10a
11	Activities	34,959	18,909	59,166	113,034		113,034	(736)	112,298			11
12	Social Services	4,772		18,264	23,036		23,036		23,036			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	843,057	138,127	326,341	1,307,525		1,307,525	(2,657)	1,304,868			16
	C. General Administration											
17	Administrative	180,000		426,000	606,000		606,000	(273,119)	332,881			17
18	Directors Fees											18
19	Professional Services			22,687	22,687	(4,871)	17,816	3,383	21,199			19
20	Dues, Fees, Subscriptions & Promotions			13,722	13,722		13,722	(8,974)	4,748			20
21	Clerical & General Office Expenses	43,546	29,108	112,415	185,069		185,069	117,227	302,296			21
22	Employee Benefits & Payroll Taxes			166,118	166,118	34,631	200,749		200,749			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,365	2,365		2,365		2,365			24
25	Other Admin. Staff Transportation			727	727		727	1,839	2,566			25
26	Insurance-Prop.Liab.Malpractice			66,683	66,683		66,683	849	67,532			26
27	Other (specify):*							35,590	35,590			27
28	**TOTAL General Administration**	223,546	29,108	810,717	1,063,371	29,760	1,093,131	(123,205)	969,926			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,341,282	715,938	1,514,878	3,572,098	(4,871)	3,567,227	(134,358)	3,432,869			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

4621 CORPORATION D/B/A ST. MARTHA MANOR
0023770
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	34,631	
2	FOOD		34,631

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	4,871	
19	PROFESSIONAL FEES		4,871

To reclass cost of appealing real estate taxes

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR #0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			51,424	51,424		51,424	51,213	102,637			30
31	Amortization of Pre-Op. & Org.							1,711	1,711			31
32	Interest			1,957	1,957		1,957	103,074	105,031			32
33	Real Estate Taxes			99,758	99,758	4,871	104,629	5,792	110,421			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles			13,048	13,048		13,048	(248)	12,800			35
36	Other (specify):*											36
37	**TOTAL Ownership**			406,187	406,187	4,871	411,058	(78,458)	332,600			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			7,447	7,447		7,447	(5,963)	1,484			41
42	Provider Participation Fee			72,608	72,608		72,608		72,608			42
43	Other (specify):*			398	398		398	(398)				43
44	**TOTAL Special Cost Centers**			80,453	80,453		80,453	(6,361)	74,092			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,341,282	715,938	2,001,518	4,058,738		4,058,738	(219,177)	3,839,561			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,130)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(67)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(110)	21		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,714)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,248)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(32,074)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,843)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(155,334)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (155,334)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (219,177)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

4621 CORPORATION D/B/A ST. MARTHA MANOR

ID# 0023770

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	TRUST FEES	(724)	21	2
3	MISCELLANEOUS INCOME	(316)	21	3
4	PPA - DUES	(19)	20	4
5	PPA - THERAPY CONSULTING	(1,313)	10A	5
6	PPA - EQUIPMENT RENTAL	(248)	35	6
7	PPA - PENALTY	(1,045)	21	7
8	PPA - NURSING SUPPLIES	(608)	10	8
9	PPA - PROFESSIONAL FEES	(293)	19	9
10	PPA - ACTIVITIES	(736)	11	10
11	PPA - R&M	(3,442)	6	11
12	PPA - FOOD	(431)	2	12
13	DEPRECIATION ON NON-CARE ASSET	(3,600)	30	13
14	NON-ALLOWABLE TRAVEL	(398)	43	14
15	VENDING INCOME	(5,963)	41	15
16	CAPITALIZED R&M	(12,938)	6	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(32,074)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(498)											(498)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			880		1,218							2,098	5
6	Maintenance	(16,380)		6,243		41							(10,096)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(16,878)		7,123		1,259							(8,496)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(608)											(608)	10
10a	Therapy	(1,313)											(1,313)	10a
11	Activities	(736)											(736)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,657)											(2,657)	16
	C. General Administration													
17	Administrative			(426,000)	42,881	110,000							(273,119)	17
18	Directors Fees													18
19	Professional Services	(293)		3,676									3,383	19
20	Fees, Subscriptions & Promotions	(10,233)		1,259									(8,974)	20
21	Clerical & General Office Expenses	(11,443)		68,470		60,200							117,227	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation			1,839									1,839	25
26	Insurance-Prop.Liab.Malpractice			849									849	26
27	Other (specify):*			11,936	4,192	19,462							35,590	27
28	**TOTAL General Administration**	(21,969)		(337,971)	47,073	189,662							(123,205)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,504)		(330,848)	47,073	190,921							(134,358)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(15,730)	59,793	6,068		1,082							51,213	30
31	Amortization of Pre-Op. & Org.		1,711										1,711	31
32	Interest		80,908	22,166									103,074	32
33	Real Estate Taxes			3,927		1,865							5,792	33
34	Rent-Facility & Grounds		(240,000)										(240,000)	34
35	Rent-Equipment & Vehicles	(248)											(248)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(15,978)	(97,588)	32,161		2,947							(78,458)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(5,963)											(5,963)	41
42	Provider Participation Fee													42
43	Other (specify):*	(398)											(398)	43
44	**TOTAL Special Cost Centers**	(6,361)											(6,361)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(63,843)	(97,588)	(298,687)	47,073	193,868							(219,177)	45

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	60.00%	SEE ATTACHED		SEE ATTACHED		
DANIEL O'BRIEN	20.00%	SEE ATTACHED		SEE ATTACHED		
MARY O'BRIEN	20.00%	SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 240,000	4621 BUILDING CORPORATION	100.00%	$	$ (240,000)	1
2	V	30	DEPRECIATION		4621 BUILDING CORPORATION		59,793	59,793	2
3	V	31	AMORTIZATION		4621 BUILDING CORPORATION		1,711	1,711	3
4	V	32	INTEREST EXPENSE		4621 BUILDING CORPORATION		80,908	80,908	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 240,000			$ 142,412	$ * (97,588)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 880	$ 880	15
16	V	6	REPAIRS AND MAINT.		MADO MGMT. LP		6,243	6,243	16
17	V	19	PROFESSIONAL FEES		MADO MGMT. LP		3,676	3,676	17
18	V	20	DUES AND SUBSCRIPTIONS		MADO MGMT. LP		1,259	1,259	18
19	V	21	CLERICAL AND GENERAL		MADO MGMT. LP		68,470	68,470	19
20	V	25	AUTO EXPENSE		MADO MGMT. LP		1,839	1,839	20
21	V	26	PROPERTY INSURANCE		MADO MGMT. LP		849	849	21
22	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		11,936	11,936	22
23	V	30	DEPRECIATION		MADO MGMT. LP		6,068	6,068	23
24	V	32	INTEREST		MADO MGMT. LP		22,166	22,166	24
25	V	33	REAL ESTATE TAXES		MADO MGMT. LP		3,927	3,927	25
26	V	17	MANAGEMENT FEES	426,000	MADO MGMT. LP			(426,000)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 426,000			$ 127,313	$ * (298,687)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	$	MADO MGMT. LP	100.00%	$ 3,770	$ 3,770	15
16	V	27	EMP. BEN.-D. O'BRIEN		MADO MGMT. LP		1,298	1,298	16
17	V								17
18	V	17	SALARY-P. O'BRIEN		MADO MGMT. LP		33,333	33,333	18
19	V	27	EMP. BEN.-P. O'BRIEN		MADO MGMT. LP		2,397	2,397	19
20	V								20
21	V	17	SALARY-C. STUMPF		MADO MGMT. LP		5,778	5,778	21
22	V	27	EMP. BEN.-C. STUMPF		MADO MGMT. LP		497	497	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 47,073	$ * 47,073	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 1,218	$ 1,218	15
16	V	6	REPAIRS AND MAINTENANCE		MADO MGMT. LP		41	41	16
17	V	17	ADMINISTRATIVE SALARY		MADO MGMT. LP		110,000	110,000	17
18	V	21	CLERICAL SALARY		MADO MGMT. LP		60,200	60,200	18
19	V	27	GEN. ADMIN. - EMP. BEN.		MADO MGMT. LP		19,462	19,462	19
20	V	30	DEPRECIATION-WAREHOUSE		MADO MGMT. LP		1,082	1,082	20
21	V	33	REAL ESTATE TAXES		MADO MGMT. LP		1,865	1,865	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 193,868	$ * 193,868	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$ 33,118	WINDY CITY NURSING	100.00%	$ 33,118	$	15
16	V	10	NURSING	230,319	WINDY CITY NURSING		230,319		16
17	V	11	ACTIVITIES	53,864	WINDY CITY NURSING		53,864		17
18	V	12	SOCIAL SERVICE	18,264	WINDY CITY NURSING		18,264		18
19	V	21	OFFICE	87,582	WINDY CITY NURSING		87,582		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 423,147			$ 423,147	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTH # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL O'BRIEN	OWNER	Administrative	20.00%	SEE ATTACHED	3	7.50	SALARY	$ 180,000	17-1	1
2	DANIEL O'BRIEN	OWNER	Administrative	20.00%	SEE ATTACHED	3	7.50	Alloc-Mado	3,770	17-7	2
3	PETER O'BRIEN	OWNER	Administrative	60.00%	SEE ATTACHED	6	10.00	Alloc-Mado	33,333	17-7	3
4	CHARLES STUMPF	RELATIVE	Administrative		SEE ATTACHED	2	4.44	Alloc-Mado	5,778	17-7	4
5	KATHLEEN STUMPF	RELATIVE	Administrator		SEE ATTACHED	35	77.77	Alloc-Mado	110,000	17-7	5
6	BRIDGET STUMPF	RELATIVE	Asst. Admin.		SEE ATTACHED	40	100.00	Alloc-Mado	60,200	17-7	6
7	JAMES WEST	RELATIVE	Clerical		SEE ATTACHED	7.5	18.75	Alloc-Mado	9,529	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 402,610		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	243,330	5	$ 4,695	$	45,613	$ 880	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	243,330	5	33,305		45,613	6,243	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	243,330	5	19,610		45,613	3,676	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	243,330	5	6,715		45,613	1,259	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	243,330	5	365,265	298,189	45,613	68,470	5
6	25	AUTO EXPENSE	PATIENT DAYS	243,330	5	9,811		45,613	1,839	6
7	26	PROPERTY INSURANCE	PATIENT DAYS	243,330	5	4,530		45,613	849	7
8	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	243,330	5	63,675		45,613	11,936	8
9	30	DEPRECIATION	PATIENT DAYS	243,330	5	32,369		45,613	6,068	9
10	32	INTEREST	PATIENT DAYS	243,330	5	118,247		45,613	22,166	10
11	33	REAL ESTATE TAXES	PATIENT DAYS	243,330	5	20,949		45,613	3,927	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 679,171	$ 298,189		$ 127,313	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	30,158	30,158	3	3,770	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	10,385		3	1,298	2
3										3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	250,000	250,000	6	33,333	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	17,978		6	2,397	5
6										6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	130,000	130,000	2	5,778	7
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	11,175		2	497	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 449,696	$ 410,158		$ 47,073	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	1,218			1,218	1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1	41			41	2
3	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	303,237	303,237		110,000	3
4	21	CLERICAL SALARY	DIRECT ALLOCATION		3	80,490	80,490		60,200	4
5	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	51,678			19,462	5
6	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1	1,082			1,082	6
7	33	REAL ESTATE TAXES	AVG. HOURS WORKED		1	1,865			1,865	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 439,611	$ 383,727		$ 193,868	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WINDY CITY NURSING
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAOG, IL 60610
Phone Number: (773) 787-9400
Fax Number: (773) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	DIRECT ALLOCATION			$	$		$ 33,118	1
2	10	NURSING	DIRECT ALLOCATION						230,319	2
3	11	ACTIVITIES	DIRECT ALLOCATION						53,864	3
4	12	SOCIAL SERVICE	DIRECT ALLOCATION						18,264	4
5	21	OFFICE	DIRECT ALLOCATION						87,582	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 423,147	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	4621 BUILDING CORP	X		MORTGAGE	$16,355.00	12/28/98	$ 1,100,000	$ 1,049,540	12/31/08		$ 80,908	1
2												2
3												3
4												4
5												5
	Working Capital											
6	INSURANCE FINANCE CHAR		X								1,957	6
7												7
8												8
9	TOTAL Facility Related				$16,355.00		$ 1,100,000	$ 1,049,540			$ 82,865	9
	B. Non-Facility Related*											
10	Supplemental Schedule										22,166	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 22,166	14
15	TOTALS (line 9+line14)						$ 1,100,000	$ 1,049,540			$ 105,031	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA M # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
1	ALLOC-MADO	X					$	$			$ 22,166	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 22,166	21

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	103,620	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	105,001	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,381	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	104,169	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	4,871	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	110,421	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	93,224	8
	1996	97,457	9
	1997	93,832	10
	1998	99,879	11
	1999	99,209	12

CALCULATION OF 2000 ACCRUAL = 99209 X 1.05 = 104169.00

ALLOCATED FROM MADO - 5792.00

1999 ACCRUAL FROM COST REPORT = 1999 COST REPORT FIGURE - ADJ TO ACCRUAL

104873+1253 = 103620

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,364 B. General Construction Type: Exterior _____ Frame FIRE RETARDENT Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 17,111
2. Number of Years Over Which it is Being Amortized: 15 YEARS; 10 YEARS
3. Current Period Amortization: 1,711
4. Dates Incurred: 1985, 1998

Nature of Costs: AMORTIZATION OF LOAN COSTS - BUILDING COMPANY
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY - BLDG CO	12,868	1984	$ 70,700	1
2					2
3	TOTALS	12,868		$ 70,700	3

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	132		1984		$ 1,494,824	$ 59,793	30	$ 49,827	$ (9,966)	$ 757,786	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	541		20			541	9
10	Various			1979	38,105		20			38,105	10
11	Various			1981	22,244		20			22,244	11
12	Various			1982	12,527		20			12,527	12
13	Various			1983	5,530		20			5,530	13
14	Various			1984	25,958		20			25,958	14
15	Various			1985	10,641		20			10,641	15
16	Various			1986	13,635	682	20	682		5,456	16
17	Various			1987	65,231		20			65,231	17
18	Various			1988	30,395	275	20	275		30,395	18
19	Various			1990	115,949	5,107	20	5,107		66,928	19
20	Various			1991	10,000	1,680	20	1,680		982	20
21	Various			1992	22,069	1,104	20	1,104		15,955	21
22	Various			1993	17,651	883	20	883		9,712	22
23	Various			1994	12,220	611	20	611		4,277	23
24											24
25	PAGE 12-1 REP TOTALS				79,440	3,100		2,568	(532)	14,468	25
26											26
27											27
28											28
29											29
30											30
31	PAGE 12E TOTALS				33,521	514		664	150	664	31
32	PAGE 12D TOTALS				63,454	2,039		2,112	73	2,394	32
33	PAGE 12C TOTALS				84,145	4,207		4,207		6,734	33
34	PAGE 12B TOTALS				50,231	2,677		2,514	(163)	6,369	34
35	PAGE 12A TOTALS				210,738	10,601		10,698	97	57,833	35
36	TOTAL (lines 4 thru 35)				$ 2,419,049	$ 93,273		$ 82,932	$ (10,341)	$ 1,160,730	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1995	109,219	5,355	20	5,355		37,100	9
10	ROOF REPAIRS			1996	14,096	608	20	705	97	3,234	10
11	TILES			1996	2,067	103	20	103		516	11
12	WAREHOUSE ROOF			1996	5,400	270	20	270		1,358	12
13	VENTS - BOILER PIPE			1996	680	34	20	34		170	13
14	DRYWALL WORK			1996	3,308	165	20	165		826	14
15	GLASS BLOCK WINDOWS			1996	2,810	141	20	141		705	15
16	DOORS			1997	7,335	367	20	367		1,414	16
17	NURSES CALL STATION			1997	3,450	173	20	173		591	17
18	ELEVATOR WORK			1997	1,717	86	20	86		337	18
19	SECURITY SYSTEM			1997	12,147	607	20	607		1,872	19
20	CEMENT REPLACEMENT			1997	678	68	20	68		261	20
21	ELEVATOR DOOR REPLAC			1997	750	75	20	75		288	21
22	FIRE ALARM REPAIRS			1997	3,227	323	20	323		1,238	22
23	NEW ELEVATOR DOORS			1997	2,400	120	20	120		370	23
24	ELEVATOR DOOR REPLAC			1997	645	65	20	65		249	24
25	BOILER REPAIRS			1997	850	43	20	43		133	25
26	BATHROOM IMPROVEMENT			1997	9,498	475	20	475		1,821	26
27	TILE			1997	17,363	868	20	868		3,327	27
28	BOILER REPAIRS			1997	720	36	20	36		111	28
29	BOILER REPAIRS			1997	3,243	162	20	162		500	29
30	PIPE/CONCRETE REPLAC			1997	815	41	20	41		140	30
31	BOILER REPAIRS			1997	885	44	20	44		136	31
32	COMPRESSOR REPAIRS			1997	655	33	20	33		116	32
33	HEAT AIR COND			1997	1,688	84	20	84		301	33
34	PLUMBING			1997	1,782	89	20	89		304	34
35	FIRE DAMPERS			1998	3,310	166	20	166		415	35
36	TOTAL (lines 4 thru 35)				$ 210,738	$ 10,601		$ 10,698	$ 97	$ 57,833	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEVATOR REPAIRS			1998	1,664	83	20	83		228	9
10	LIGHTING & SIGN			1998	3,886	194	20	194		582	10
11	DOOR REPAIRS			1998	500	25	20	25		75	11
12	HOT WATER HEATER			1998	645	32	20	32		83	12
13	KITCHEN ELECTRIC			1998	563	28	20	28		79	13
14	DOORS & A/C UNIT			1998	3,795	190	20	190		428	14
15	FIRE DAMPERS			1998	985	49	20	49		139	15
16	BATHROOM IMPROV			1998	3,670	184	20	184		445	16
17	ELEVATOR REPAIRS			1998	2,411	121	20	121		343	17
18	PIPE REMOVAL			1998	1,230	62	20	62		181	18
19	63 FIRE GUARDS			1998	1,816	91	20	91		243	19
20	DOOR REPAIRS			1998	1,840	92	20	92		245	20
21	DOOR REPAIRS			1998	586	29	20	29		73	21
22	FIRE PROOFING			1998	4,100	205	20	205		581	22
23	HAND RAILS			1998	750	38	20	38		114	23
24	ROOF REPAIRS			1998		163	20		(163)		24
25	ALARM REPAIR			1998	1,317	66	20	66		143	25
26	GATE REPAIR			1998	925	46	20	46		104	26
27	DOOR REPAIRS			1998	745	37	20	37		89	27
28	FAUCETS			1998	630	32	20	32		77	28
29	PAVING			1998	3,950	198	20	198		462	29
30	BOILER REPAIR			1998	1,431	72	20	72		162	30
31	DOOR REPAIR.			1998	3,525	176	20	176		396	31
32	PLUMBING			1998	1,475	74	20	74		167	32
33	TILES			1998	3,133	157	20	157		340	33
34	31 FIRE GUARDS			1998	893	45	20	45		120	34
35	SHEET METAL			1998	3,766	188	20	188		470	35
36	TOTAL (lines 4 thru 35)				$ 50,231	$ 2,677		$ 2,514	$ (163)	$ 6,369	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF REPAIRS			1998	1,800	90	20	90		195	9
10	2X2 BRIGHTONS			1998	1,610	81	20	81		189	10
11	NEW ROOF-KITCHEN			1999	1,600	80	20	80		147	11
12	LANDSCAPING			1999	1,425	71	20	71		101	12
13	NEW COMPRESSOR			1999	925	46	20	46		69	13
14	PAINT & DECOR			1999	567	28	20	28		37	14
15	FIREPROOFING OF BLDG			1999	1,995	100	20	100		192	15
16	5 STEEL DOORS			1999	6,375	319	20	319		452	16
17	KITCHEN REPAIR			1999	600	30	20	30		35	17
18	LANDSCAPING			1999	3,000	150	20	150		213	18
19	10 BATHROOMS			1999	7,700	385	20	385		513	19
20	PAINT & DECOR			1999	649	32	20	32		48	20
21	DECORATING			1999	1,203	60	20	60		100	21
22	DECORATING			1999	2,820	141	20	141		223	22
23	PAINT & DECOR			1999	828	41	20	41		82	23
24	WALL CABINETS			1999	3,163	158	20	158		263	24
25	24 GAUGE PREFIN.PANE			1999	7,312	366	20	366		519	25
26	HAND RAILINGS			1999	1,650	83	20	83		166	26
27	FLOORING			1999	1,563	78	20	78		117	27
28	METAL DOORS			1999	1,975	99	20	99		198	28
29	CERAMIC FLOORING			1999	5,905	295	20	295		541	29
30	30 NEW DOOR CLOSURE			1999	2,050	103	20	103		137	30
31	LANDSCAPING			1999	1,000	50	20	50		67	31
32	ALUMINUM FRAME DOOR			1999	7,000	350	20	350		671	32
33	FLOOING			1999	2,341	117	20	117		234	33
34	FLOORING			1999	589	29	20	29		56	34
35	CONCRETE WALK			1999	16,500	825	20	825		1,169	35
36	TOTAL (lines 4 thru 35)				$ 84,145	$ 4,207		$ 4,207	$	$ 6,734	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORING			1999	2,536	127	20	127		254	9
10	LAUNDRY CEILING REPA			1999	600	30	20	30		35	10
11	LANDSCAPING			1999	1,810	91	20	91		121	11
12	METAL DOORS			1999	844	42	20	42		81	12
13	LANDSCAPING			1999	825	41	20	41		55	13
14	KITCHEN REPAIR			1999	1,800	90	20	90		105	14
15	KITCHEN REPAIR			1999	1,100	55	20	55		60	15
16	DOOR HINGES			1999	1,429		20	71	71	71	16
17	BLINDS			1999	828	41	20	41		65	17
18	BLINDS			1999	531	27	20	27		50	18
19	ELEVATOR REP	*		2000	1,279	27	20	27		27	19
20	SINK REPAIR	*		2000	550		20	2	2	2	20
21	PLUMBING WORK			2000	2,038	68	20	68		68	21
22	DOORS & FRAMES			2000	3,083	154	20	154		154	22
23	SPRINKLER	*		2000	948	47	20	47		47	23
24	SMOKE DETECTOR/WRNG			2000	590	25	20	25		25	24
25	ELEVATOR REPAIRS			2000	799	30	20	30		30	25
26	PIPE INSTALLATION			2000	2,383	89	20	89		89	26
27	3/4 PUMPMOTOR"			2000	1,107	55	20	55		55	27
28	ELEVATOR REP			2000	1,241	52	20	52		52	28
29	FIRE ALARM PAVEL	*		2000	2,136	27	20	27		27	29
30	TILE	*		2000	2,893	97	20	97		97	30
31	COUNTER TOPS	*		2000	2,055	52	20	52		52	31
32	BOILER INSTALL	*		2000	18,885	315	20	315		315	32
33	STEAM TRAPS/VALVES			2000	1,314	61	20	61		61	33
34	ELEVATOR REP			2000	8,175	375	20	375		375	34
35	OIL PRESSURE SWITCH	*		2000	1,675	21	20	21		21	35
36	TOTAL (lines 4 thru 35)				$ 63,454	$ 2,039		$ 2,112	$ 73	$ 2,394	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLEY DOOR	*		2000	640		20	19	19	19	9
10	ELEVATOR REPAIRS	*		2000	1,259	180	20	180		180	10
11	ALARM SYSTEM			2000	639	27	20	27		27	11
12	BRICK WALLS	*		2000	12,200	102	20	102		102	12
13	CEMENT WORK	*		2000	3,390	43	20	43		43	13
14	DOOR SAFETY LOCK	*		2000	2,350	10	20	10		10	14
15	METER GUAGE	*		2000	1,173	30	20	30		30	15
16	ALARM SYSTEM	*		2000	584	24	20	24		24	16
17	LANDSCAPING	*		2000	1,099		20	37	37	37	17
18	SINK	*		2000	687		20	20	20	20	18
19	SIDE RAILS	*		2000	775		20	16	16	16	19
20	MINI BLINDS	*		2000	2,390		20	10	10	10	20
21	SPRINKLER SYSTEM	*		2000	562		20	12	12	12	21
22	TOILETS	*		2000	1,025		20	17	17	17	22
23	WATER FLOW SWITCH	*		2000	761		20	10	10	10	23
24	BOILER HEAD	*		2000	705		20	9	9	9	24
25	A/C MODIFICATION			2000	1,505	50	20	50		50	25
26	FIRE PUMP REP			2000	1,094	37	20	37		37	26
27	ALARM SYSTEM	*		2000	683	11	20	11		11	27
28											28
29	* - ADDED AFTER FILING OF 6/30/00 CAPITAL PROJECTION										29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 33,521	$ 514		$ 664	$ 150	$ 664	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			MADO	1988	$ 38,854	$ 1,413		$ 1,110	$ (303)	$ 5,551	4
5			MADO	1985	21,630	1,082		618	(464)	3,090	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOC-MADO MGMT			1995	901	211	20	45	(166)	248	9
10	ALLOC-MADO MGMT			1993	14,800	394	20	710	316	5,494	10
11	ALLOC-MADO MGMT			2000	3,255		20	85	85	85	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 79,440	$ 3,100		$ 2,568	$ (532)	$ 14,468	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MA # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 136,246	$ 11,838	$ 9,946	$ (1,892)		$ 89,168	37
38	Current Year Purchases	14,378	707	810	103		810	38
39	Fully Depreciated Assets	130,613	3,949	3,949			130,613	39
40								40
41	TOTALS	$ 281,237	$ 16,494	$ 14,705	$ (1,789)		$ 220,591	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	1998 BMW	1998	$ 25,000	$ 5,000	$ 5,000	$	5	$ 12,500	42
43										43
44										44
45										45
46	TOTALS			$ 25,000	$ 5,000	$ 5,000	$		$ 12,500	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,795,986	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 114,767	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 102,637	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (12,130)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,393,821	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	1988 MERCEDES	$ 54,359	$	$ 54,359	52
53	1998 BMW	18,000	3,600	9,000	53
54					54
55					55
56					56
57	TOTALS	$ 72,359	$ 3,600	$ 63,359	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

4621 CORPORATION D/B/A ST. MARTHA MANOR
0023770
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
CORP. 4621 D.B.A. ST. MARTHA MANOR	114,665	7,788	7,788		82,653
ALLOCATED FROM MADO MANAGEMENT	21,581	4,050	2,158	(1,892)	6,515
TOTALS	136,246	11,838	9,946	(1,892)	89,168
LINE 29: CURRENT YEAR					
CORP. 4621 D.B.A. ST. MARTHA MANOR	13,077	707	769	62	769
ALLOCATED FROM MADO MANAGEMENT	1,301		41	41	41
TOTALS	14,378	707	810	103	810
LINE 30: FULLY DEPRECIATED					
CORP. 4621 D.B.A. ST. MARTHA MANOR	130,613	3,949	3,949		130,613
ALLOCATED FROM MADO MANAGEMENT					
TOTALS	130,613	3,949	3,949		130,613
TOTALS (Should Tie to Totals on Page 13)					
CORP. 4621 D.B.A. ST. MARTHA MANOR	258,355	12,444	12,506	62	214,035
ALLOCATED FROM MADO MANAGEMENT	22,882	4,050	2,199	(1,851)	6,556
TOTALS	281,237	16,494	14,705	(1,789)	220,591

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 0 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 12,801 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service		Cost	Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs		$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**										13
14	TOTAL				$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,066	$ 5,796	1
2	Cash-Patient Deposits	25,866	25,866	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,150,437	1,165,668	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,274	20,274	6
7	Other Prepaid Expenses	(49,813)	(49,813)	7
8	Accounts Receivable (owners or related parties)	2,939,443	3,903,091	8
9	Other(specify): See supplemental schedule	18,762	18,762	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,110,035	$ 5,089,644	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		70,700	13
14	Buildings, at Historical Cost		1,494,824	14
15	Leasehold Improvements, at Historical Cos	957,357	957,357	15
16	Equipment, at Historical Cost	255,782	255,782	16
17	Accumulated Depreciation (book methods)	(651,087)	(2,026,324)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		17,111	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,422)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	3,100	3,100	22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 565,152	$ 769,128	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,675,187	$ 5,858,772	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 419,929	$ 454,929	26
27	Officer's Accounts Payable	9,168	9,168	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,923	43,923	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,170	104,170	32
33	Accrued Interest Payable		9,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	6,234	6,234	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	963,646	963,646	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,547,070	$ 1,591,070	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,049,540	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,049,540	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,547,070	$ 2,640,610	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,128,117	$ 3,218,162	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,675,187	$ 5,858,772	48

*(See instructions.)

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
OTHER RECEIVABLE	5,124	5,124
LOAN RECEIVABLE	4,025	4,025
WAGE ASSIGNMENTS	719	719
EMPLOYEE ADVANCES	8,893	8,893
	18,761	18,761

OTHER CURRENT LIABILITIES:	Amount	Amount
ACCRUED RENT	963,649	963,649
	963,649	963,649

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,431,180	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,431,180	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	696,937	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 696,937	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,128,117	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	4621 CORPORATION D/B/A ST. MA	#	0023770	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		2,431,180
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		2,431,180
Equity(Deficit) from Page 17 Col 1		3,128,117
Related Party		
Equity(Deficit)	90045	
Income	0	
		90,045
Combined Equity - End of Year		3,218,162

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MAN # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,749,396	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,749,396	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	5,963	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 5,963	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	316	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 316	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,755,675	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,201,202	31
32	Health Care	1,307,525	32
33	General Administration	1,063,371	33
	B. Capital Expense		
34	Ownership	406,187	34
	C. Ancillary Expense		
35	Special Cost Centers	7,845	35
36	Provider Participation Fee	72,608	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,058,738	40
41	**Income before Income Taxes (line 30 minus line 40)****	696,937	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 696,937	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number 4621 CORPORATION D/B/A ST. M # 0023770 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	MISC INCOME (ADJUSTED OFF ON PAGE 5)	316
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	316

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,718	5,794	116,843	20.17	3
4	Licensed Practical Nurses	20,421	21,520	280,366	13.03	4
5	Nurse Aides & Orderlies	54,521	57,370	406,117	7.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,907	1,957	17,680	9.03	9
10	Activity Assistants	2,066	2,149	17,279	8.04	10
11	Social Service Workers	448	459	4,772	10.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,530	17,193	98,754	5.74	15
16	Dishwashers					16
17	Maintenance Workers	12,319	12,908	89,266	6.92	17
18	Housekeepers	12,519	13,274	86,266	6.50	18
19	Laundry	76	76	392	5.16	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	156	156	180,000	1153.85	22
23	Office Manager					23
24	Clerical	4,428	4,863	43,546	8.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	131,109	137,719	$ 1,341,281 *	$ 9.74	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	141	$ 3,525	1-3	35
36	Medical Director	56	3,628	9-3	36
37	Medical Records Consultant	96	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	20	1,645	10A-3	40
41	Occupational Therapy Consultant	22	1,390	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	13	689	10A-3	43
44	Activity Consultant	89	4,646	11-3	44
45	Social Service Consultant				45
46	Other(specify) REHAB CONSULT	129	7,208	10A-3	46
47	SEE ATTACHED		105,902		47
48					48
49	TOTAL (lines 35 - 48)	566	$ 132,665		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8,900	$ 214,227	10-3	50
51	Licensed Practical Nurses	1,119	16,092	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	10,019	$ 230,319		53

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MA # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DANIEL O'BRIEN	ADMINISTRATIVE	20.00%	$ 180,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 180,000

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - MADO MANAGEMENT	$ 426,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 426,000

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEMS	DATA PROCESSING	$ 4,604
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	974
FR&R	ACCOUNTING	9,368
WOLF AND CO.	ACCOUNTING	2,869
PRS. CONSULTING LC	APPRAISER	2,400
HYNES JOHNSON & MCNAMARA	LEGAL	2,471
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 22,686

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,028
Unemployment Compensation Insurance	8,175
FICA Taxes	98,979
Employee Health Insurance	
Employee Meals	34,631
Illinois Municipal Retirement Fund (IMRF)*	
GROUP INSURANCE	36,809
401 K CONTRIBUTION	127
TOTAL (agree to Schedule V, line 22, col.8)	$ 200,749

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	572
(Indicate # of checks performed 54)	
LICENSES, FEES	2,717
ALLOC-MADO	1,259
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,748

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,365
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,365

**See instructions.

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number 4621 CORPORATION D/B/A ST. MARTHA MANOR # 0023770 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **33,095** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **72,468**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **34,631** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **At Nursing Home of MGMT Co.**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw